Article

Feminism & Psychology

The feminisation of contraceptive use: Australian women's accounts of accessing contraception

Feminism & Psychology
2015, Vol. 25(2) 178–198

DOI: 10.1177/0959353514562802
fap.sagepub.com
SAGE

Britta Wigginton
The University of Queensland, Australia

Melissa L. Harris
University of Newcastle, Australia

Deborah Loxton
University of Newcastle, Australia

Danielle Herbert
Cerebral Palsy Alliance, Australia

Jayne Lucke
The University of Queensland, Australia; La Trobe University, Australia

Abstract

The oral contraceptive pill remains the most widely used contraceptive method. We consider The Pill's depiction as variously revolutionary and liberating, oppressive for women, and more recently, a 'lifestyle drug'. Drawing on discourses of (hetero)sex, heterosexuality and gender performance, we discuss how contraceptive use has been feminised and consider the current gap in understanding how women negotiate their positioning as responsible for contraception. To begin to fill this gap, we conducted a thematic discourse analysis using 75 free-text responses (to a general question in a wider contraceptive survey) to explore how women account for their agency and responsibility in discussions of accessing contraception. We identified two themes: responsibility for education and information and 'finding contraceptive fit'. Women's discussions of responsibility for education and information highlight the need for

Corresponding author:
Britta Wigginton, UQ Centre for Clinical Research, The University of Queensland, Building 71/918, Royal Brisbane and Women's Hospital Site, Herston 4029, Queensland, Australia.
Email: b.wigginton@uq.edu.au

transparency from educational bodies, which are positioned as lacking in their delivery of contraceptive information. Women describe "finding contraceptive fit" as an embodied process of experimentation with contraception to ultimately find one with minimal negative side effects. We situate our findings within critiques of the gendered nature and production of health, conceptualising contraceptive use as a distinctly feminine practice, which promotes self-surveillance and embodied awareness.

Keywords
contraception, contraceptive use, access, gender, responsibility, thematic discourse analysis, side effects

A wide range of contraception is available to women in developed countries, such as Australia, where contraceptive use is common among young heterosexual women of reproductive age (Newman et al., 2011). Available forms of female contraception include vaginal rings, intrauterine devices (IUDs), implants, injectables, a range of oral contraceptive pills (Lucke, Watson, & Herbert, 2009) and emergency contraception (Hussainy et al., 2011). In contrast, the condom is the only available male form of reversible contraception (Oudshoorn, 2004).

The Oral Contraceptive Pill (The Pill) is an oral, hormonal contraceptive, requiring daily intake. Long-acting reversible contraceptives only need replacing after a number of years, and include both hormonal (Implant or the Mirena) and nonhormonal (the Copper IUD) options. Despite developments in long-acting contraception, to improve rates of unintended pregnancies and reduce costs for women, their uptake has been comparatively low in Australia (Richters, Grulich, de Visser, Smith, & Rissel, 2003) except in regional[1] areas (Lucke & Herbert, 2014). By comparison, The Pill is the most frequently prescribed (Mazza et al., 2012) and used contraceptive in Australia (Lucke et al., 2009; Parr & Siedlecky, 2007; Richters et al., 2003), the US (Jones, Mosher, & Daniels, 2012) and the UK (Lader, 2007).

In this paper, we consider how broader discourses and the local discursive context of our survey feminise contraceptive use, positioning women as responsible for contraception. Specifically, we consider The Pill's emergence as revolutionary through its current depiction as a "lifestyle drug" (Watkins, 2012), and the ways in which using The Pill fits with discourses of heterosexuality, (hetero)sex and gender performance. In light of a material and discursive landscape that favours women as *the* contraceptive users, our analysis focuses on how women account for their agency and responsibility in accessing contraception and information about contraception.

Contextualising the 'popularity' of The Pill

The release of The Pill in America in 1960 was groundbreaking. It represented the first prescription-only oral hormonal contraceptive available to women. Prior to The Pill, available contraceptive methods included the diaphragm (with

spermicidal jelly), condoms, douching, natural family planning (or the rhythm method) and withdrawal. Feminists in the 1950s were largely enthusiastic about The Pill, a technology that was seen to emancipate women (Tone, 2012), allowing greater control over fertility and family planning (Marks, 2001).

During this time, there were eugenic undertones regarding the birth control movement, an effort designed to keep "undesirable" populations in check and instil a general fear of overpopulation (Ruhl, 2002). For instance, clinical trials to determine the safety and effectiveness of The Pill (named Enovid) were carried out on low-income Puerto Rican women – who represented an "overpopulated, under-developed" population (Cream, 1995). This testing was carried out to ensure that The Pill was safe for its *intended* user: the fertile, Western upper middle-class woman who was both deserving of, and trusted with, an effective contraceptive (Takeshita, 2010). Despite these eugenic messages circulating at the time, The Pill represented a significant development and opportunity. Accordingly, many celebrated The Pill for its enabling effects on women's lives. This celebration and cultural acceptance are evidenced by the 1.2 million American women who were using The Pill within two years of its release (Tone, 2012).

Resistance to the development of The Pill was varied. The Roman Catholic Church has long opposed the development of contraception, considering such technologies as dangerous as they encourage sexual promiscuity and compromise the place of "Mother Nature" (Tone, 2002). According to Purdy (1996), "progressive left" feminists also adopted an inherently negative position, cautioning others about the danger of contraceptive technologies as they reinforce biologically deterministic stereotypes for women. However, there were safety concerns about The Pill, and the importance of informed consent, which prompted further feminist critiques in the 1970s (Watkins, 1998) and led to developing the IUD as an alternative contraceptive (Takeshita, 2012). The most radical critique, at the time, argued that The Pill was an "ill-conceived, poorly tested contraception foisted on women through the collusion of the drug industry and the medical profession" (Watkins, 1998, p.5). It was also around this time that the feminist women's health movement gained momentum, driven by themes of empowerment, control and autonomy – which later informed critiques of male-dominated medicine (Kaler, 2004). More recently, feminists have responded cautiously to reproductive technologies, like contraception, highlighting how these technologies place increased pressure on women to take responsibility for reproductive matters (Sawicki, 1999).

While contraception was initially developed to prevent pregnancy in a context of limited reproductive autonomy, today, the marketing and development of female contraception are very different. In particular, the noncontraceptive benefits of contraception are emphasised to market particular brands of contraceptives to women (Watkins, 2012). In a postfeminist society where sexual liberation has been 'achieved', contraception is now designed to free women from menstruation. For instance, Seasonale was the first extended cycle oral contraceptive pill marketed solely for menstrual suppression (Mamo & Fosket, 2009). This shift fits within a neoliberal agenda, where women are positioned as consumers of a "lifestyle drug" with certain desirable (contraceptive and noncontraceptive) effects. The body in this

way becomes a project for self-perfection allowing transformative effects for subjectivity (Mamo & Fosket, 2009). Specifically, women can be freed from the ''inconvenience'' of menstruation (Granzow, 2014), creating a more productive (nonmenstruating) female body ready for full participation in the workforce (Kissling, 2012).

While the meanings attached to female contraception have shifted over the past 50 years, women's contraceptive practices are embedded within a web of discourses shaping heterosexuality, (hetero)sex and gender. Hollway (1989) identified three competing discourses, which underpin the meanings and practices attached to (hetero)sex, to understand how women and men are positioned by, and position themselves within, these discourses. Here, (hetero)sex is defined as penis–vagina sex or ''real sex'' (Gavey, McPhillips, & Braun, 1999). The ''male sex drive'' discourse constructs men as biologically wanting and needing sex, where women's sexuality is absent and instead they are passive objects to men's desire. Within the ''permissive'' discourse, equal and free sexual expression among women and men is celebrated, with a focus on pleasure (not reproduction) and a negotiation of reciprocity. Finally, within the ''have/hold'' discourse, (hetero)sex is encouraged to take place within a long-term relationship. Apparently gender neutral, this discourse is more stringently applied to women in cooperation with the ''male sex drive'' discourse. Lowe (2005b) argues that the ''male sex drive'' and 'have/hold' discourse construct men as both ''powerful'' and ''uncontrollable'' in their sexual desire and women as sexually passive and rational, which together reinforces women's responsibility for contraception. Here the assumption is that women are more likely to use contraception because of their risk to pregnancy and their state of rationality (Lowe, 2005b).

Dominant constructions of (hetero)sex also produce a similar effect. In particular, within (hetero)sex the ''intense'' and ''spontaneous'' nature of sex (Pollack, 1985) and a level of intimacy and sensory pleasure (Braun, 2013) are prioritised. These constructions influence the acceptability of certain contraceptives as either facilitating or disrupting how (hetero)sex *should* be experienced. In Braun's (2013) work with young people, she found they mobilised these discourses to discount the need for condoms. She concluded that ''such accounts work to conceptually separate condoms from 'desirable' sex; condoms are constructed as not synonymous with, or even oppositional to, things that sex *is* or *should be* about, such as passion, or romance'' (p.372, emphasis in original). Therefore, with cultural understandings of (hetero)sex as spontaneous, pleasurable and intimate, condoms become a less desirable contraceptive. The use of female contraception, however, fits within the hegemonic criteria of (hetero)sex and the positioning of women as rational (as posited within the 'male sex drive' discourse). In particular, female contraception allows women to be prepared for sex without necessarily expecting sex – reinforcing the notion of spontaneity (Lowe, 2005b). In addition, unlike condoms, female contraception[2] does not interrupt sex, does not threaten the ''naturalness'' of sex and most importantly it does not compromise men's pleasure – in line with the ''male sex drive'' discourse. In this way, the use of female contraception facilitates the construction and experience of ''real sex''.

Female contraception has also been discussed in the context of gender theory. In particular, within a matrix of heterosexuality, Cream (1995) has argued that the practice of taking The Pill conforms with Judith Butler's theory of gender performance, and in particular the notion of "intelligible genders". That is, "intelligible" genders are those which in some sense institute and maintain relations of coherence and continuity among sex, gender, sexual practice, and desire" (Butler, 1990, p.17). In this way, a heterosexual, fertile woman taking The Pill makes sense, whereas a man or a postmenopausal woman does not. Cream proposes that, in the context of contraception, the body becomes a site of gender performance, where using The Pill allows an expression of identity and gender configuration that is culturally "intelligible", in a Western context.

We argue that the combination of these discourses feminises contraceptive use[3] which positions women as primary consumers of contraception. In this light, the practice of using contraception allows for an enactment of feminine and heterosexual identities, as well as an expression of responsibility and agency. Within this discursive landscape, continuing developments into female contraceptive options are viewed unproblematically as empowering women to "plan" and "control" their fertility. Such an approach to contraception reproduces gendered expectations around *who* is responsible for pregnancy prevention, and *how* responsibility should be performed, thereby limiting the discursive space for "shared" responsibility. Our issue is that gendered approaches to reproduction imply that heterosexual men do not have an active role in reproductive health, and problematically, that they are "not interested" in such issues (Terry & Braun, 2011). Drawing on Oudshoorn (2004), our concern is that the feminisation of contraceptive use has limited the discursive space for heterosexual men to be involved in contraception and stagnated developments into reversible forms of male contraception.

We were interested in women's accounts of accessing contraception in light of the feminisation of contraceptive use. In particular, our exploration occurs in a setting in which these gendered discourses were prevalent: a survey examining the contraception and pregnancy experiences of young Australian women. Rather than viewing these gendered assumptions, which were embedded into the design of our project, as a limitation, we allowed these to enrich our interpretations. Consequently, we viewed women's participation in our survey as an enactment and negotiation of responsibility. A discursive lens allowed us to attend to both structural and local discourses which call women to account for their contraceptive practices. In order to move beyond the prescriptive effects of these discourses, we were interested in how women negotiated, and articulated, their agency and responsibility in their accounts of accessing contraception or information about contraception.

Method

Participants

We used various online and offline recruitment channels (including social media, face-to-face events and media releases) to recruit a cohort of young Australian

women aged 18–23 years to complete a survey on their contraceptive and pregnancy experiences (Harris, Loxton, Wigginton, & Lucke, in press). The project was approved by three Ethics Committees. The data used in this analysis included responses from 75 women from New South Wales and Queensland, Australia. Most women were in full-time study ($n = 55$), working casually ($n = 36$) or part time ($n = 15$). The majority of women indicated they lived > 10 km from a medical clinic or doctor ($n = 66$). Most common reasons women indicated for using hormonal contraception (including The Pill) in the past six months included for "protection" ($n = 54$) and to manage menstrual pain ($n = 23$), with some women using it for both ($n = 21$). In relation to the last time women had vaginal sex, most used The Pill ($n = 35$) or condoms ($n = 30$), with a small number using both methods ($n = 13$), while only three women reported not using any contraception.

Measures

With the overarching aim of examining factors that influence contraceptive use, our online survey concentrated on a number of specific themes including: sociodemographics (e.g. work/study status); knowledge about, and attitudes to, contraception (e.g. feelings about the choice to use contraception); sexual and reproductive health histories (e.g. history of miscarriage); and health service use (e.g. doctor consultations). Most items were quantitative (with fixed response options) with some open-ended questions. At the end of the survey, participants were asked: "Is there anything else you would like to tell us about? Contraception (protection), your plans for pregnancy, or your experience of pregnancy. Please write in the space below". Responses to this question served as the source of data for the analysis here.

Although there was variability in the length of women's responses, ranging from a few sentences to multiple paragraphs, we were more concerned with the extent to which the data allowed an in-depth analysis of our research question. Previously, the use of online qualitative survey data has been criticised for lacking the depth and richness appropriate for qualitative analysis (Garcia, Evans, & Reshaw, 2004). However, we argue, along with others, that such data are entirely appropriate for qualitative analysis, where a data set should be judged according to the significance of the interpretation and its usefulness in maximising the positive social change outcomes from the research (Beckett & Clegg, 2007; Peel, 2012; Rich, Chojenta, & Loxton, 2013). Therefore, given our interest in the negotiation of gendered discourses surrounding contraception, we viewed our data as an opportunity to examine women's negotiation of these discourses within a setting in which women were held accountable for their contraceptive practices (namely, the survey).

Analysis

The data analysed here were extracted from a larger data set of 891 participants (downloaded on 7 February 2013), of which 164 women responded to the open-ended question at the end of the survey. The first author extracted 75 responses that

were deemed, on a semantic level, to be descriptions of accessing contraception or information about contraception. Our descriptive criteria allowed us to select responses that were orienting to a similar topic (i.e. descriptions of accessing contraception) and a topic in which women were likely to be accounting for their agency and responsibility for contraception. We recognise that the use of the final question meant that women were likely to have already discussed issues relating to accessing contraception. However, due to the absence of a specific open-ended question about accessing contraception, we chose to analyse the final question because it included a discussion of a range of topics that were not otherwise accessible in our data – a benefit of including an "anything else" question. Excerpts selected for analysis were kept as close to the original text response as possible, with the exception of corrected spelling and grammar for improved readability.

The first author conducted a thematic discourse analysis drawing on the guidelines of Braun and Clarke (2006) and applying a discursive lens to consider the ideological and political implications of women's accounts (Clarke, 2005; Taylor & Ussher, 2001). We were interested in women's experiences of accessing contraception, acknowledging their social construction through language, where "knowledge is transient and inherently unstable [. . .], closely associated with power" (Gavey, 1989, p.462). Following Parker (1992), we understood discourses as a "system of statements which constructs an object" (p.5). In other words, a discourse shapes the way in which an object (event or phenomenon) can be understood and spoken about in a particular sociocultural context.

Conducted by the first author, the analysis started with iterative readings, followed by a process of initial coding to identify the ways in which women accounted for accessing contraception. Once initial codes were generated, the first author reiteratively organised the data into meaningful themes that reflected common ways of accounting for accessing contraception and information about contraception. Coming from the perspective that women are both the producers and products of discourse (Davies & Harré, 1990), we were interested in identifying the ways in which women negotiated their agency and responsibility for accessing contraception. Applying a discursive lens to the identified themes, we paid attention to how women formulated their accounts of accessing contraception, how they positioned themselves and others and the discursive consequences of these constructions and positions. We explore women's agency and responsibility in relation to two themes: responsibility for education and information and finding the "right" contraceptive.

Responsibility for education and information

Across the data, women stressed the importance of information and education regarding contraception. Many women emphasised the need to access information about the effects of contraception (including side effects, potential long-term effects and risks) and the different contraceptive options.

> I know that I am not the participant you are looking for in this survey, but I feel there should be more research done into and more information available about the side effects of these contraceptive medications, and about their alternatives (i.e. abstinence, natural family planning). [18 years, in casual work and full-time study, in heterosexual relationship not living together]

> From my personal research I believe The Pill (and almost all other forms of hormonal contraceptives) to be highly damaging to the female body and I feel that very few doctors express these risks to their patients or are possibly not aware of the risks themselves. I believe there needs to be a lot more information and transparency of the risks involved in taking these contraceptives and especially in taking them for extended periods of time, or at a young age as most people do. I believe that it is very problematic that many young women and girls view The Pill as a safe, responsible, and normal thing to take, and often end up taking it for up to 10 or 15 years before becoming fully aware of the effects it has on their bodies. [22 years, in full-time work, living with male partner]

In the excerpts above, women orient to a need or expectation for transparency regarding contraceptive side effects, options and risks. Both women emphasise their personal opinion regarding the current status of information and education around contraception as lacking (''but I feel''; ''I believe''). In particular, ''educators'' are positioned as lacking in their delivery of contraceptive education and knowledge (''should be more research done into and more information available''; ''there needs to be a lot more information''). In this way, the responsibility for educating and informing is placed on some external body that educates women. In the second excerpt, doctors are labelled as a specific information source that is lacking, as indicated by their positioning as either gatekeepers to information or as ignorant.

In relation to women's expressions of agency, in the second excerpt, the woman emphasises her agency in seeking information about contraception. In particular, her claims about the damaging effects of long-term use of The Pill and the extent to which such information is hidden from women are supported by her information-seeking practices (''from my personal research''). Our interpretation is that her expression of agency (her information seeking practices) allowed her to make claims that challenge the cultural acceptance and normalisation of The Pill (as indicated by the phrase ''I believe it is very problematic many young women and girls view The Pill as a safe, responsible, and normal thing to take'').

Building on the notion that women do not currently receive enough, or need more, information about contraception, the following excerpts show other ways in which women orient to their position as *recipients* of education:

> I think females need to be more educated about different types of contraception and the possible side effects of contraceptives (e.g. fertility). [23 years, in full-time work, in heterosexual relationship not living together]

> I have been on the Pill since I was 15, not for contraception but for hereditary issues that it needs to control. My not wanting children stems from this and will most likely mean I am on contraception for my entire life. What does worry me is that healthcare professionals say that contraception like The Pill may cause breast cancer and I think that more information, if any, should be more available to young girls thinking of beginning oral contraception methods. [18 years, in part-time work and full-time study, in heterosexual relationship not living together]

> I believe that women are not given enough information regarding The Pill and Vaccines. The Pill can leave women barren and so many are not told this, drugs that are used in the morning after pill are used in lethal injection in the US The Cervical Cancer vaccine that is so highly recommended by doctors has left a 19 year old girl barren. Abstinence has been promoted in the Philippines and the rise of Aids has dramatically reduced, in Africa the use of Condoms was promoted and Aids has risen. Why aren't people told these things!!! [19 years, in part-time work and full-time study, single]

Above, women orient to their limited access to education or information about contraception (as indicated by: ''females need to be more educated''; ''more information, if any, should be more available to young girls''; ''women are not given enough information''). In these accounts, agency is attributed to those who *should* be educating women, and women are positioned as recipients of education. This conflicts with neoliberal discourse, in which women are expected to be autonomous and responsible in matters of reproductive health (Stuart & Donaghue, 2012), including educating themselves about the various options and side effects. Interestingly, across these three accounts, women use a collective label to refer to women in general as needing education (as indicated by ''females''; ''young girls''; ''women''). It is highly likely that the consistent reference to women as a group (and also the absence of men) is reflective of the context in which the data were produced. However, speaking to the rhetorical effects of this label and what function it may serve in women's accounts, we argue that the framing of women in general allows women to construct an account that does not threaten their own agency or identity, but instead focuses on the lack of education currently provided to them. Speaking about being uninformed or uneducated potentially threatens one's identity – especially in the context of our survey which called for women to account for their contraceptive practices, experiences and knowledge. Therefore, discussing women as a group, and shifting some responsibility on to an external body that is meant to ''educate'' women, may have allowed women to share the burden of needing to ''be informed'' (in line with neoliberal discourse) with a third party. This pattern of accounting is present in the following excerpts:

> I feel that there's not enough information provided through school and advertisements/pamphlets about the more unheard of types of contraception eg. Vaginal ring, Implanon, IUD. These other methods of contraception aren't publicised enough and

> unless somebody actively seeks information about them they remain an abstract and somewhat unknown-about method. If these other forms of contraception were more publicised for their own benefits then girls especially would be better informed to raise the topic with their doctor and find the type of contraception perfect for them – rather than a 17 year old girl asking for and obtaining the pill because that's the only method she's ever heard about, then missing days and reducing its effectiveness because she has a busy lifestyle. If she were better informed, she might instead decide on the implant or an IUD, therefore reducing her personal risk of pregnancy. [18 years, in part-time work and full-time study, in heterosexual relationship not living together]

> There isn't enough readily available information about the various different contraceptive options and how to really use them effectively. How can anyone expect girls and boys to know what method will be most suitable for them when doctors and chemists treat the choices as assumed knowledge? I believe that the contraceptive information available today only skims the surface, and that more explicit education about how to physically use them is needed in order for us to be able to make a more informed choice about contraceptive method used. [22 years, in full-time study, living with male partner]

In the accounts above, the women similarly orient to the lack of information available either through "school and advertisements/pamphlets" or through "doctors and chemists". In both cases, these specific sources of information are positioned as failing to educate young people about the different types of contraception ("the more unheard of types of contraception"; "various different contraceptive options"). As a result of the failed agency of these educational bodies, women (and in the second excerpt, "boys") are not held solely responsible for seeking information. Rather, external sources are responsible for the hidden nature of contraceptive information. The expectation for "girls" to "be better informed" (first excerpt) and "girls and boys to know what method will be most suitable" (second excerpt) is shared with these educational sources. Therefore, the 'informed' woman (or contraceptive user) who finds a contraceptive that best suits her lifestyle is possible in a context that better informs her (indicated by "if she were better informed"; "more explicit education [. . .] is needed in order for us to be able to make a more informed choice").

As we will explore in the second theme, the accounts above allude to the notion of a "perfect" or "suitable" contraceptive. That is, a contraceptive that suits a woman's lifestyle and effectively prevents pregnancy. In this way, an "informed" woman is able to practice responsibility through using the "right" contraceptive – not just any contraception. This identity work is similar to that reported in an interview study by Granzow (2008), where Canadian women constructed *using* contraception as a means of demonstrating their responsibility. However, in the above accounts, the responsibility for using the "perfect" contraceptive is shared with educational sources ("schools and advertising"; "doctors and chemists"), who

currently fail to provide women with "enough information" to find contraceptive "fit". The following excerpt reiterates the limited education delivered in schools:

> I have always thought that there needs to be more information about ALL the options for contraception available to high-school aged girls (and boys). At school we heard about various methods however only The Pill was ever really discussed and offered as an option. However, at uni I went looking for other options and found something that suited my partner and myself better than the obvious – but only because I asked. [22 years, in casual work and full-time study, engaged in heterosexual relationship]

In the excerpt above, the woman constructs herself as authentically endorsing ("I have always thought") the notion that there should be more information available to "girls (and boys)" about "ALL" the contraceptive options. Here, the inclusion of boys in parenthesis is likely to be reflective of the local discursive context. In describing the limited education provided at high school, the woman goes on to highlight her own role in taking initiative for her contraception at university and searching for a "better" contraceptive for her and her partner. Her autonomy is emphasised by using a discovery metaphor ("I went looking [. . .] and found something") to account for her role in seeking a "better" contraceptive for her and her partner. Her agency is further qualified by the phrase "but only because I asked" at the end of her excerpt, suggesting that without governing herself to find a suitable contraceptive, they would be left with "the obvious".

Across this discursive theme, women were constructing the need for information about "all" forms of contraception. Recent research conducted with Australian women also expressed the importance of contraceptive information, which was described as currently lacking (Dixon, Herbert, Loxton, & Lucke, 2014), particularly, with respect to risks and benefits of using The Pill (Philipson, Wakefield, & Kasparian, 2011). In our data, transparency was clearly important; however, the responsibility for education and information was shifted to educational bodies. Women often discussed the need for women in general to be informed and educated by these external sources. While we acknowledge this may be reflective of the local context in which these data were produced, from a rhetorical perspective, we offer a novel interpretation regarding the usefulness of this framing. In particular, general labels protect women's identities, minimising the relevance of their own experience and potential lack of knowledge, and instead shifting the focus to the majority who need to be educated.

'Finding contraceptive fit'

A central feature across the data was women's descriptions of their embodied experiences of using contraception. In particular, women identified unwanted side effects that led them to stop using particular contraceptives and subsequently try other contraceptive methods. We came to understand these descriptions of

embodied experimentation with contraception as a practice we labelled "finding contraceptive fit":

> I have tried The Pill but found it impossible to remember to take it daily. I have tried the 3-monthly injections but they made me put on 20 kgs in 6 months and irregulated my menstrual cycle. I have tried the implant that is inserted in the arm, this caused me to have my menstrual cycle non-stop without a break. All methods of contraception have been very unsatisfactory for me. And condoms are just uncomfortable and irritating. I am interested at the moment in the Marima [Mirena] but wish to gather more information before I try it. [22 years, in full-time study, in heterosexual relationship not living together]

> Both of the hormonal contraceptive methods I've used (implanon and yaz pill) have caused serious mood effects such as depression, anxiety and anger, so I've had to stop using them. I am considering trying Paragard, or different pills to find something I can use. At this point, thinking of contraception at all makes me feel depressed, it feels like nothing will work properly. [19 years, in casual and part-time work and full-time study, in heterosexual relationship not living together]

> As stated previously, I was previously on the pill for a number of years and loved it. I had regular periods, great skin and a good sex life. However, I started getting reoccuring migraines and was forced to discontinue this therapy. I initially tried the mini pill but had issues with constant bleeding. I have since been trying to find a similar therapy and have had to try a multitude of contraceptives, none of which I have been very happy about. I tried the Nuva Ring and my partner and I could feel it during intercourse. My partner could feel the Mirena implant during intercourse as well. After discontinuing the pill, I developed severe acne that the pill had obviously suppressed. I have since gone on a successful course of Isotretinoin and as such, have had to use two forms of contraception (condoms and the Implanon implant). A few months after I discontinue the Isotretinoin, I plan to discontinue the use of condoms and rely solely on the protection provided by implanon as my partner and I have been in a relationship for three and a half years. Overall, I am frustrated with a lack of contraception that has effects similar to the pill for those women who are migraine sufferers. [22 years, in full-time study, in heterosexual relationship not living together]

Above, women offer extensive accounts of their experiences with different contraceptives, each with their unique side effects (weight gain, irregular menstrual cycle, mood effects, migraines). Women similarly emphasise side effects as a precursor to stopping or switching contraception. For instance, in the first account, the woman's use of repetition ("I have tried") allows her to emphasise the extent of her attempts to find a "satisfactory" contraceptive – one without effects of weight gain or an irregular menstrual cycle. Women's references to these noncontraceptive side effects buttress their accounts and provide embodied (and therefore legitimate)

evidence that supports their contraceptive changes and decisions. To illustrate, in the first and second excerpts, women mobilise a cause and effect discourse to articulate, with certainty, the ''serious'' effects that using contraception had on their menstrual cycle or mood.

What is notable across these three accounts is the extent of women's articulations of ''finding contraceptive fit''. That is, no matter how serious the side effects women described experiencing, or how frustrated they were feeling (''thinking of contraception at all makes me feel depressed, it feels like nothing will work properly''), there was always another female contraceptive that women were considering to try. The assumption being that eventually they will find a contraceptive that ''works''. This in itself highlights women's commitment to, and agency afforded through, the embodied practice of ''finding contraceptive fit'' – a practice that requires self-surveillance with respect to finding a contraceptive with minimal side effects.

In the third excerpt above, the embodied visibility of contraception (specifically, feeling the contraceptive during (hetero)sex) is described as leading to switching contraception. This ties into notions of how (hetero)sex *should* be experienced, where contraception should not be felt or compromise pleasure, in line with ''the male sex drive'' discourse (as indicated by ''My partner could feel the Mirena''). The following excerpt similarly shows how ''finding contraceptive fit'' occurs within the context of (hetero)sex, as well as experiences of side effects and access to contraception:

> The side effects of the pill make it a real turn off to use, even though it's one of the easier contraceptives to attain. Condoms are much easier to get, use and are also cheaper. From experience, they have been the most reliable. However, the ''plastic'' feel sometimes means that having unsafe sex happens. [19 years, in casual work and full-time study, in heterosexual relationship not living together]

Above, the woman describes the side effects of The Pill as the ultimate ''turn off'' for using this contraceptive, despite its easy access. She describes the advantages of condoms (easy to access and use, cheap and reliable) suggesting, however, that these are compromised by the ''plastic feel'' which often leads to ''unsafe sex''. Previous qualitative work has also identified the ''plastic feel'' as compromising ''safe sex'' because it disrupts a central and important feature of (hetero)sex, that is, pleasure (Braun, 2013) – although it is not clear in our data *whose* pleasure is compromised. Interestingly, in the excerpt above, the use of embodied descriptions (side effects and ''plastic feel'') provides legitimate evidence to account for *not* using a particular contraceptive.

The accounts below show how women's social position implicates their experiences of ''finding contraceptive fit'':

> Before children options for contraception is limited to those that are sensitive or reactive to hormones. My pill costs on average for 3 months $50-70. All my money goes towards it being a student as its all I don't react to I have been recommended an

> IUD but not until AFTER children and this is still a while away. This leaves me financially restricted and limited in my contraception freedom. [21 years, in casual work and full-time study, in heterosexual relationship not living together]

> I feel that some doctors are biased towards giving young women longer-term contraceptive methods (Mirena IUD) due to their age and the idea that they may want children soon. I have had problems with my menstrual cycle since it began, the Mirena IUD sounded like a good option for me, but I had to try multiple types of contraceptive pills before my doctor would agree to insert it because it was considered a ''last resort'' for women my age. I also feel like I am not taken seriously when I say that I do not plan on having children. [22 years, in casual work and full-time study, living with male partner]

The women above similarly describe wanting to use an IUD. Despite the IUD being a better fit for these women, because of their reactions to hormonal contraception (first excerpt) or menstrual cycle problems (second excerpt), both describe difficulty in accessing this contraceptive because it is more appropriate for older women or women who have already had children. Although official guidelines do not restrict IUD use to nulliparous women, sociocultural events have shaped *who* constitutes the ''ideal'' IUD user. Specifically, in response to initial safety concerns regarding an early IUD (the Dalkon Shield) and its effect on women's fertility, subsequent IUDs have been marketed towards the ''older monogamous mother'' (see Takeshita, 2010). Both women in these excerpts orient to the ideal IUD user as a woman who has had children or is older (''recommended an IUD but not until AFTER children'', ''a 'last resort' for women my age''). However, the woman in the second excerpt expresses difficulty challenging the assumption that all women (eventually) have children (''I am not taken seriously when I say that I do not plan on having children''). These two excerpts are the only two instances of our sample of data where women orient to certain identities being more compatible with particular contraceptives, highlighting the need for further research into how identities (and identity performance) are tied to contraceptive use.

Together, women's accounts of ''finding contraceptive fit'' were described as an embodied practice that involved a level of self-surveillance regarding their body and contraceptive side effects – consistent with gendered attitudes towards the ''healthy'' body as needing to be regulated (Moore, 2010). Women conceptualised ''contraceptive fit'' as a contraceptive with minimal undesirable side effects (avoiding weight gain, negative moods and constant or irregular menstrual bleeding). ''Finding fit'' was also located in dominant discourses of (hetero)sex and heterosexuality, where the naturalness and pleasure of (hetero)sex is prioritised. Previous work has similarly indicated pleasure is an important factor influencing the discontinuation of condoms (Braun, 2013; Williamson, Buston, & Sweeting, 2009). Women expressed agency by highlighting the lengths they went to, in order to find suitable contraception, drawing on embodied evidence to legitimise their accounts. As we have shown, some women's agency was compromised by the incongruence between their social position (as young and childfree) and a culturally

constructed criterion for who constitutes the "ideal" contraceptive user (specifically, the IUD, see: Takeshita, 2010).

Discussion

We discursively analysed women's accounts of accessing contraception and information about contraception, with an interest in how women negotiated agency and responsibility in light of structural and local discourses, which position women as responsible for contraception. We identified two discursive themes, responsibility for education and information and "finding contraceptive fit", which were the focus of this article.

First, women articulated a need for transparency in information about contraceptive options, side effects and risks, similar to recent work with Australian women (Dixon et al., 2014; Philipson et al., 2011). In our data, women overwhelmingly described the lack of education or information from various external sources, including schools, doctors, chemists and advertising. While previous research has found the embodied and gendered nature of contraceptive information to be highly relevant to women, for instance, in determining the trustworthiness or legitimacy of knowledge sources (Carter, Bergdall, Henry-Moss, Hatfield-Timajchy, & Hock-Long, 2012; Lowe, 2005a; Picardo, Nichols, Edelman, & Jensen, 2002), we did not identify such a pattern. Rather, the way in which women's accounts were framed uniquely suggested that these external sources were, at least in part, responsible for women's lack of information and education about contraception. Offering a discursive interpretation, it could be said that this framing allowed women to share their responsibility for being informed and educated about contraception with external bodies, and potentially avoid the self-blame that comes along with that responsibility, should something go wrong with their contraception (e.g. "unintended" pregnancy). However, as feminist researchers, we feel it is important that we listen to women's accounts. Therefore, we read these data on a more realist level, as a call for more attention to improving the availability of education and information surrounding contraception both in schools and clinical settings (e.g. consultations with doctors).

Second, our identification of "finding contraceptive fit" offered the first conceptualisation of an embodied and agentic practice that is part of accessing and using contraception. Here, women described a level of self-surveillance with respect to side effects, in sourcing a contraceptive that was right for them (and at times, also their partner). Women's accounts of "finding fit" were embedded in discourses of (hetero)sex to suggest that certain contraceptives that were "felt" during (hetero)sex, or reduced pleasure (e.g. condoms), constituted embodied evidence that supported women's discontinuation or inconsistent use. At least for condoms, our analysis fits within a growing body of work that shows how condoms may compromise "safe sex" because they disrupt dominant discourses of (hetero)sex (Braun, 2013; Lowe, 2005b). However, there is limited discussion within the literature about how female contraceptives, in particular, coital-based methods, may disrupt dominant discourses of (hetero)sex, as we and Lowe (2005b) found. Again, this ties to earlier

discussions of female contraception working alongside dominant discourses of heterosexuality and (hetero)sex, highlighting the power of these discourses in shaping material practices, and the way in which material practices reinforce these discourses.

We identified two instances in which women's social positions (as child free and young) implicated their access to an IUD, which they believed was a better "fit" for them, because an IUD's "ideal" contraceptive user is considered to be the 'older monogamous mother' (see Takeshita, 2010). Our analysis suggested that women's autonomy in accessing contraception, and therefore "finding contraceptive fit", may be compromised by their identity positions, something women may have to negotiate in contraceptive consultations in order to access their preferred contraceptive. Building on our analysis and work by Cream (1995) and Takeshita (2010), future research could examine the ways in which identity and gender theories could be applied to women's experiences of using and accessing contraception. For instance, what identity positions are associated with emergency contraception, long-acting contraception or daily hormonal contraception (e.g. The Pill) and how do women negotiate these identities in decision making around accessing and using particular contraceptives? Exploring these questions could offer a more nuanced understanding of women's contraceptive decision making.

We locate our findings within Moore's (2010) work on health as a gendered project. She argues that the overwhelming focus on self-control, body-consciousness and self-surveillance is symbolic of a feminine attitude towards the ("at risk") body. Such a view of the body as an object, which one must seek to control and maintain, means that health is taken up and marketed as a form of self-expression, part of promoting the body as a moral project. In the context of our data, Moore's argument fits with the ways in which accessing and using contraception (specifically, "finding contraceptive fit") are constructed as a feminised practice, which involves self-surveillance and embodied awareness. For instance, while side effects have previously been identified in the literature as an important factor leading to discontinuation (Hoggart & Newton, 2013; Mills & Barclay, 2006), our analysis suggested that side effects provided legitimate evidence for women's contraceptive decisions, including discontinuation. Similarly, Littlejohn (2013) points to the social and gendered meanings attached to side effects (e.g. weight gain and mood). In Littlejohn's interviews, women described high levels of emotional side effects, most commonly anger and sadness, as undesirable because they wanted to avoid nonnormative displays of emotions that might label them as "irrational". Therefore, we suggest future research should explore the production of feminine identities in women's accounts of contraceptive use and experiences of side effects, to better understand how "doing health", or using contraception, is synonymous with "doing gender" (Moore, 2010) and how this shapes how women story their reproductive health. This would offer useful insight into the constructive and restrictive effects of gendered narratives of contraceptive use.

As we have highlighted, our contraceptive project reproduced gendered notions of responsibility in matters of reproductive health. However, we viewed our data as an opportunity to examine women's accounts within a gendered setting that called for them to account for their responsibility and agency for contraception.

Therefore, our analysis contributes to understanding the ways in which accessing contraception, and by extension, responsibility for contraception, is understood and experienced as a gendered practice, in line with Terry and Braun (2011) in their work regarding men and vasectomies. In challenging gendered expectations surrounding contraception – and reproduction more broadly – we need to continue to expose the invisible ''male reproductive body'' (Oudshoorn, 2004). Hence, material changes in contraceptive practices are needed (e.g. the male contraceptive pill), in order to open up discursive spaces for heterosexual men's involvement in contraception so as to move towards a model of shared responsibility. In addition, continuing the dialogue around men's lack of contraceptive options is important in pushing for material changes.

Conclusion

In this article, we have explored women's accounts of accessing contraception with an interest in how women negotiate their agency and responsibility within a context which feminises contraceptive use, thereby positioning women as the primary consumers of contraception. Our data illustrate the complexity of women's contraceptive use and the competing and multiple discourses that shape and constrain women's agency. We suggest future research considers the ways in which ''doing health'' (specifically, using contraception) may be tied to notions of ''doing gender''. Therefore, a focus on women's identity work in discussions of their contraceptive use (and nonuse) is warranted.

For psychologists, these findings offer insight into the ways in which contraceptive use is femininised, thereby placing unequal expectations on women, compared to men. Therefore, in promoting women's reproductive autonomy, we urge psychologists and clinicians to support women's agency regarding their reproductive needs (i.e. contraception) while being aware of the ways in which their professional practices may be reproducing gendered expectations regarding contraceptive use. For instance, in the context of contraceptive consultations, we recommend clinicians discuss all available contraceptive methods, including the male condom. In addition, clinicians should be aware of, and respect, the extent to which women's embodied experiences (e.g. side effects) may reflect legitimate ''evidence'' which supports women's decision to discontinue a particular contraceptive.

Funding

The research on which this paper is based was supported under the Australian Research Council's *Linkage Projects* funding scheme (Project Number LP100200349). We are grateful to the Australian Research Council and partner organisations, Family Planning NSW and Bayer Australia Ltd for their financial support.

Acknowledgements

Thank you to all the women who kindly shared their experiences with us. Also, thank you to the editor and anonymous reviewers for their very helpful suggestions on early versions of this manuscript.

Notes

1. Regional areas refer to nonmetropolitan areas of Australia. This classification is based on a precise geographic measure of remoteness (independent of socioeconomic factors), which assesses population size and distance to services, according to Australian Standard Geographical Classification (GISCA, 2010). Locations are categorised as ''major cities'', ''inner regional'', ''outer regional'' and ''remote''. Here, we combine the two categories of regional to refer to locations that have smaller populations and a greater distance to services compared to ''major cities''.
2. Although we use the term ''female contraception'' here, we acknowledge that some women report being able to feel certain contraceptives during (hetero)sex, such as the Mirena intrauterine device (IUD) or vaginal ring. Therefore, in making the argument that female contraception faciliates (hetero)sex, we acknowledge that in some cases, this excludes coital methods of contraception.
3. Borrowing Tone's (2012) term, ''the feminisation of contraception'' to refer to the ways in which developments into contraception have been femininsed, we use the term ''feminisation of contraceptive use'' to argue that using contraception is a gendered practice of ''doing'' health (see Mamo & Foskett, 2009 and Cream, 1995 for more on gendered subjectivities and contraception).

References

Beckett, C., & Clegg, S. (2007). Qualitative data from a postal questionnaire: Questioning the presumption of the value of presence. *International Journal of Social Research Methodology*, *10*, 307–317.

Braun, V. (2013). 'Proper sex without annoying things': Anti-condom discourse and the 'nature' of (hetero)sex. *Sexualities*, *16*, 361–382.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77–101.

Butler, J. (1990). *Gender trouble: Feminism and the subversion of identity*. New York, NY: Routledge.

Carter, M. W., Bergdall, A. R., Henry-Moss, D., Hatfield-Timajchy, K., & Hock-Long, L. (2012). A qualitative study of contraceptive understanding among young adults. *Contraception*, *86*, 543–550.

Clarke, V. (2005). 'We're all very liberal in our views': Students' talk about lesbian and gay parenting. *Lesbian & Gay Psychology Review*, *6*, 2–15.

Cream, J. (1995). Women on trial: a private pillory? In: S. Pile, & N. Thrift (Eds), *Mapping the subject: Geographies of cultural transformation* (pp. 158–169). London, England: Routledge.

Davies, B., & Harré, R. (1990). Positioning: The discursive production of selves. *Journal for the Theory of Social Behaviour*, *20*, 43–63.

Dixon, S. C., Herbert, D. L., Loxton, D., & Lucke, J. C. (2014). 'As many options as there are, there are just not enough for me': Contraceptive use and barriers to access among Australian women. *The European Journal of Contraception and Reproductive Health Care*, *19*, 340–351.

Garcia, J., Evans, J., & Reshaw, M. (2004). ''Is there anything else you would like to tell us'' – Methodological issues in the use of free-text comments from postal surveys. *Quality and Quantity*, *38*, 113–125.

Gavey, N. (1989). Feminist poststructuralism and discourse analysis: Contributions to feminist psychology. *Psychology of Women Quarterly*, *13*, 459–475.

Gavey, N., McPhillips, K., & Braun, V. (1999). Interruptus coitus: Heterosexuals accounting for intercourse. *Sexualities*, *2*, 35–68.

GISCA. (2010). *About ARIA+ (accessibility/remoteness index of Australia)*. North Terrace, Australia: University of Adelaide.

Granzow, K. (2008). The imperative to choose: A qualitative study of women's decision-making and use of the birth control pill. *Social Theory & Health*, *6*, 1–17.

Granzow, K. (2014). The 'nonmenstrual woman' in the new millennium? Discourses on menstrual suppression in the first decade of Extended Cycle Oral Contraception use in Canada. *Culture, health & sexuality*, *16*, 620–633.

Harris, M.L., Loxton, D., Wigginton, B., & Lucke, J.C. (in press). Recruiting online: Lessons from a longitudinal survey of contraception and pregnancy intentions of young Australian women. *American Journal of Epidemiology*.

Hoggart, L., & Newton, V. L. (2013). Young women's experiences of side-effects from contraceptive implants: A challenge to bodily control. *Reproductive Health Matters*, *21*, 196–204.

Hollway, W. (1989). Making love without contraception: Towards a theory for analysing accounts. In: W. Holloway (Ed.), *Subjectivity and method in psychology: Gender, meaning and science* (pp. 47–66). Newbury Park, CA: Sage.

Hussainy, S. Y., Stewart, K., Chapman, C. B., Taft, A. J., Amir, L. H., & Hobbs, M. K., et al. (2011). Provision of the emergency contraceptive pill without prescription: Attitudes and practices of pharmacists in Australia. *Contraception*, *83*, 159–166.

Jones, K., Mosher, W.D., & Daniels, K. (2012). Current contraceptive use in the United States, 2006–2010, and changes in patterns of use since 1995. Retrieved from http://www.cdc.gov/nchs/data/nhsr/nhsr060.pdf: National Health Statistics Reports.

Kaler, A. (2004). The female condom in North America: Selling the technology of 'empowerment'. *Journal of Gender Studies*, *13*, 139–152.

Kissling, E. A. (2012). Pills, periods, and postfeminism. *Feminist Media Studies*, *13*, 490–504.

Lader, D. (2007). *Contraception and sexual health 2006–2007*. London, England: Office for National Statistics.

Littlejohn, K. E. (2013). ''It's those pills that are ruining me'': Gender and the social meanings of hormonal contraceptive side effects. *Gender & Society*, *27*, 843–863.

Lowe, P. (2005a). Embodied expertise: Women's perceptions of the contraception consultation. *Health*, *9*, 361–378.

Lowe, P. (2005b). Contraception and heterosex: An intimate relationship. *Sexualities*, *8*, 75–92.

Lucke, J. C., & Herbert, D. L. (2014). Higher uptake of long-acting reversible and permanent methods of contraception by Australian women living in rural and remote areas. *Australian and New Zealand Journal of Public Health*, *38*, 112–116.

Lucke, J. C., Watson, M., & Herbert, D. L. (2009). Changing patterns of contraceptive use in Australian women. *Contraception*, *80*, 533–539.

Mamo, L., & Fosket, J. R. (2009). Scripting the body: Pharmaceuticals and the (re)making of menstruation. *Signs*, *34*, 925–949.

Marks, L. (2001). 'Andromeda freed from her chains': Attitudes towards women and the oral contraceptive pill, 1950–1970. *Clio medica (Amsterdam, Netherlands)*, *61*, 217.

Mazza, D., Harrison, C., Taft, A., Brijnath, B., Britt, H., & Hobbs, M., et al. (2012). Current contraceptive management in Australian general practice: An analysis of BEACH data. *Medical Journal of Australia*, *197*, 110.

Mills, A., & Barclay, L. (2006). None of them were satisfactory: Women's experiences with contraception. *Health Care for Women International*, *27*, 379–398.

Moore, S.E. H. (2010). Is the healthy body gendered? Toward a feminist critique of the new paradigm of health. *Body & Society*, *16*, 95–118.

Newman, P., Morrell, S., Black, M., Munot, S., Estoesta, J., & Brassil, A. (2011). *Reproductive and sexual health in New South Wales and Australia: Differentials, trends and assessment of data sources*. Sydney, Australia: Family Planning New South Wales.

Oudshoorn, N. (2004). ''Astronauts in the sperm world'': The renegotiation of masculine identities in discourses on male contraceptives. *Men and Masculinities*, *6*, 349–367.

Parker, I. (1992). *Discourse dynamics: Critical analysis for social and individual psychology*. London, England: Routledge.

Parr, N., & Siedlecky, S. (2007). Use of ''dual protection'' and other combinations of contraceptive methods in Australia. *Australian and New Zealand Journal of Public Health*, *31*, 567–570.

Peel, E. (2012). Moving beyond heterosexism? The good, the bad and the indifferent in accounts of others' reactions to important life events. *Psychology of Sexualities Review*, *3*, 34–46.

Philipson, S., Wakefield, C. E., & Kasparian, N. A. (2011). Women's knowledge, beliefs, and information needs in relation to the risks and benefits associated with use of The Oral Contraceptive Pill. *Journal of Women's Health*, *20*, 635–642.

Picardo, C. M., Nichols, M., Edelman, A., & Jensen, J. T. (2002). Women's knowledge and sources of information on the risks and benefits of oral contraception. *Journal of the American Medical Women's Association*, *58*, 112–116.

Pollack, S. (1985). *Sex and the contraceptive act*. Aldershot, England: Gower.

Purdy, L. M. (1996). What can progress in reproductive technology mean for women?. *Journal of Medicine and Philosophy*, *21*, 499–514.

Rich, J.L., Chojenta, C., & Loxton, D. (2013). Quality, rigour and usefulness of free-text comments collected by a large population based longitudinal study – ALSWH. *PloS ONE, 8*. doi:10.1371/journal.pone.0068832.

Richters, J., Grulich, A. E., de Visser, R. O., Smith, A. M. A., & Rissel, C. E. (2003). Sex in Australia: Contraceptive practices among a representative sample of women. *Australian and New Zealand Journal of Public Health*, *27*, 210–216.

Ruhl, L. (2002). Dilemmas of the will: Uncertainty, reproduction, and the rhetoric of control. *Signs*, *27*, 641–663.

Sawicki, J. (1999). Disciplining mothers: Feminism and the new reproductive technologies. In: J. Price, & M. Schildrick (eds.) *Feminist theory and the body*. New York: Routledge.

Stuart, A., & Donaghue, N. (2012). Choosing to conform: The discursive complexities of choice in relation to feminine beauty practices. *Feminism & Psychology*, *22*, 98–121.

Takeshita, C. (2010). The IUD in me: On embodying feminist technoscience studies. *Science as Culture*, *19*, 37–60.

Takeshita, C. (2012). *The global biopolitics of the IUD: How science constructs contraceptive users and women's bodies*. Boston: Massachusetts Institute of Technology Press.

Taylor, G. W., & Ussher, J. M. (2001). Making sense of S&M: A discourse analytic account. *Sexualities*, *4*, 293–314.

Terry, G., & Braun, V. (2011). 'It's kind of me taking responsibility for these things': Men, vasectomy and 'contraceptive economies'. *Feminism & Psychology*, *21*, 477–495.

Tone, A. (2002). Making room for rubbers: Gender, technology, and birth control before the pill. *History and Technology*, *18*, 51–76.

Tone, A. (2012). Medicalizing reproduction: The Pill and home pregnancy tests. *Journal of Sex Research*, *49*, 319–327.

Watkins, E. S. (1998). *On the pill: A social history of oral contraceptives, 1950–1970*. Baltimore, MD: Johns Hopkins University Press.
Watkins, E. S. (2012). How The Pill became a lifestyle drug: The pharmaceutical industry and birth control in the United States since 1960. *American Journal of Public Health*, *102*, 1462–1472.
Williamson, L. M., Buston, K., & Sweeting, H. (2009). Young women and limits to the normalisation of condom use: A qualitative study. *AIDS Care*, *21*, 561–566.

Author Biographies

Britta Wigginton is completing her PhD at the University of Queensland and is a part-time Research Assistant for CUPID. Britta's interests are in qualitative research and women's health.

Melissa L. Harris has a PhD in Gender and Health and is the CUPID Project Coordinator (based at the University of Newcastle). Melissa has expertise in cohort recruitment as well as conducting quantitative and qualitative research on the influences of psychosocial factors on health outcomes.

Deborah Loxton is Deputy Director of the Australian Longitudinal Study on Women's Health (ALSWH) at The University of Newcastle. Deborah has expertise in relationship dynamics and reproductive health. Her particular interests in CUPID include the impact of relationship dynamics on contraceptive use and in the experience and outcomes of young motherhood.

Danielle Herbert (PhD) is the Research Manager for the Research Foundation at the Cerebral Palsy Alliance. This role builds on Danielle's postdoctoral research experience in research management, epidemiology and reproductive health.

Jayne Lucke is the Chief Investigator of the CUPID project. Jayne is Professor of Public Health, Director of the Australian Research Centre in Sex, Health & Society at La Trobe University and Honorary Professor at The University of Queensland's Centre for Clinical Research. She is a member of the Steering Committee of the Australian Longitudinal Study on Women's Health and Associate Investigator with the Centre for Research Excellence in Women's Health in the 21st Century. Her main area of research interest is women's sexual and reproductive health, particularly contraceptive use, patterns of fertility and sexual health.